SKIN SURGERY CENTER OF VIRGINIA

**Christine S. Rausch, MD, FACMS**
**William F. Schleicher, MS, MD**

Gaskins Professional Office Park
2510 Gaskins Road
Henrico VA 23238

804.282.4940 PHONE
804.282.4941 FAX
www.mohsvirginia.com

# Demographic Sheet

*Required information for Registration and your Electronic Medical Record*

Last Name: ______________________ First Name: ______________ Middle Initial: _____ Suffix: ______

Sex: [ ] Male [ ] Female Date of Birth: ____________ SS # ______________ Occupation: ______________

Mailing Address: ______________________ City: ______________ State: _____ Zip Code: ________

Home Phone: __________________ [ ] Same as Cell Phone Work Phone: ____________________

Cell Phone: __________________ [ ] None Email: __________________ [ ] No Email

Contact Preference: [ ] Home Phone [ ] Cell Phone [ ] Work Phone [ ] Home Address

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Race: __________________ [ ] declined Ethnicity: ______________________ [ ] declined

Primary Language: [ ] English [ ] Spanish [ ] Other ______________________

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Partner

How did you hear about us? ____________________________________________

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**GUARDIAN:** Do you have a Guardian? [ ] Yes [ ] No If yes, please provide name below.

Last Name: ______________________ First Name: ______________ Middle Initial: _____ Suffix: ______

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**EMERGENCY CONTACT:**

Last Name: ______________________ First Name: ______________ Middle Initial: _____ Suffix: ______

Relationship: ______________ Phone: ______________ [ ] Home Phone [ ] Cell Phone [ ] Work Phone

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**GUARANTOR:** PARENT OR RESPONSIBLE PARTY (if different from patient)

Last Name: ______________________ First Name: ______________ Middle Initial: _____ Suffix: ______

Mailing Address: ______________________ City: ______________ State: _____ Zip Code: ________

Guarantor SS#: ______________________ Relationship to Patient: ______________________

Employer: ______________________ Occupation: ______________________

Phone: ______________________ [ ] Home Phone [ ] Cell Phone [ ] Work Phone

Email ______________________ [ ] No Email Date of Birth: ______________

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**PRIMARY CARE PROVIDER:** Office Phone Number: ______________________

First Name: ____________ Last Name: ______________ [ ] M.D. [ ] D.O. [ ] PA-C [ ] N.P. [ ] Other ______

**REFERRING PROVIDER:** Office Phone Number: ______________________

First Name: ____________ Last Name: ______________ [ ] M.D. [ ] D.O. [ ] PA-C [ ] N.P. [ ] Other ______

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**INSURANCE INFO:** Please present *insurance card* and *driver's license* during check in. Complete ***only*** if you're ***not*** the policy holder.

Primary Insurance: ______________________ Secondary Insurance: ______________________

Name of Insured: ______________________ Name of Insured: ______________________

SS # ______________ Date of Birth ________ SS # ______________ Date of Birth ________

Relationship to policy holder ______________________ Relationship to policy holder ______________________

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## HIPAA Omnibus Notice of Privacy Practices | Effective Date: April 1, 2015 | Revised: July 25, 2019

***This notice describes how medical information about you may be used and/or disclosed and how you can get access to this information. Please review it carefully.***

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information (PHI). "PHI" is information that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

**1. USES AND DISCLOSURES OF YOUR PHI** We may use and disclose your PHI in the following situations:

**Treatment:** We may use or disclose your PHI to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

**Payment:** Your PHI will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

**Health Care Operations:** We may use and disclose your PHI to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Minors:** PHI of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

**Required by Law:** We will use or disclose your PHI when required to do so by local, state, federal, and international law.

**Abuse, Neglect, and Domestic Violence:** Your PHI will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

**Judicial and Administrative Proceedings:** As sometimes required by law, we may disclose your PHI for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

**Law Enforcement:** We'll disclose your PHI for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.

**Coroners/Medical Examiners:** We disclose PHI to coroners/medical examiners to assist in fulfilling their work responsibilities and investigations.

**Public Health:** Your PHI may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.

**Health Oversight Activities:** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, licensures & other activities as authorized by law.

**Inmates:** If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose PHI to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.

**Military, National Security and other Specialized Government Functions:** If you are in the military or involved in national security or intelligence, we may disclose your PHI to authorized officials

**Immunizations:** We will provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student in which you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

**Worker's Compensation:** We will disclose only the PHI necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

**Practice Ownership Change:** If our medical practice is sold, acquired, or merged with another entity, your PHI will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.

**Breach Notification Purposes:** If for any reason there is an unsecured breach of your PHI, we'll utilize the contact information you have provided us to notify you of the breach, as required by law. In addition, your PHI may be disclosed as a part of the breach notification and reporting process.

**Research:** Your PHI may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.

**Business Associates:** We may disclose your PHI to our business associates who provide us with services necessary to operate and function as a medical practice. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your PHI.

**2. USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT**

**Communication with family and/or individuals involved in your care or payment of your care:** Unless you object, disclosure of your PHI may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.

**Disaster:** In the event of a disaster, your PHI may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.

**Fundraising:** As necessary, we may disclose your PHI to contact you regarding fundraising events and efforts. You have the right to object or opt out of these types of communications. Please let our office know if you would NOT like to receive such communications.

**3. USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION** We will not disclose or use your PHI in the situations listed below without first obtaining written authorization to do so. In addition to the uses and disclosures listed below, other uses not covered in this Notice will be made only with your written authorization. If you provide us with authorization, you may revoke it at any time by submitting a request in writing:

**Disclosure of Psychotherapy Notes:** Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death.

**Disclosures for marketing purposes** and sale of your PHI.

**4. PROTECTED HEALTH INFORMATION (PHI) & YOUR RIGHTS** The following are statements of your rights, subject to certain limitations, with respect to your PHI:

**You have the right** to inspect and copy your PHI (reasonable fees may apply): Pursuant to your written request, you have the right to inspect and copy your PHI in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the PHI and may charge a fee for the associated costs.

**You have a right** to a summary or explanation of your PHI: You have the right to request only a summary of your PHI if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

**You have the right** to obtain an electronic copy of medical records: You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your PHI is maintained in an electronic format. We'll make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required to transmit the electronic medical records.

**You have the right** to receive a notice of breach: In the event of a breach of your unsecured PHI, you have the right to be notified of such breach.

**You have the right** to request Amendments: At any time if you believe the PHI we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

**You have a right** to receive an accounting of certain disclosures: You have the right to receive an accounting of disclosures of your PHI. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.

**You have the right** to request restrictions of your PHI: You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

**You have a right** to request to receive confidential communications: You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

**You have a right** to receive a paper copy of this notice: Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

**5. CHANGES TO THIS NOTICE** We reserve the right to change the terms of this notice, will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. We will not retaliate against you for filing a complaint.

**6. COMPLAINTS** If you believe your privacy rights have been violated & you'd like to register a complaint, you may do so with us or the Secretary of the United States Department of Health & Human Services.

**HIPAA Compliance Officer:**
Mark Rausch, MD, HIPAA Compliance Officer
Christine S. Rausch MD, PC
2510 Gaskins Road Henrico, VA 23238 | 804.282.4940 | info@mohsvirginia.com

**US Department of Health & Human Services:**
www.hhs.gov/ocr/hipaa/
Phone: 202.619.0257

**The Joint Commission:**
patientsafetyreport@jointcommission.org
Fax: 630-792-5636

**7. ACKNOWLEDGMENT**
I acknowledge that I have been given the opportunity to review the HIPAA Notice of Privacy Practices and that may ask to speak with the HIPAA Compliance Officer in person or by phone at the number listed above, should I have question or concerns regarding this document. I acknowledge that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC will scan this document and destroy the original, and agree that the scanned document is the same as the original.

___________________________________________ ____________________

Signature of Patient or Responsible Party Date

___________________________________________ ____________________

Printed Name of Patient or Responsible Party Relationship to Patient

# Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices (NPP) provides information about how Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC may use and disclose Protected Health Information (PHI). As specified in the NPP, Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC intends to use and disclose the minimum necessary PHI about you for treatment, payment or health care operation purposes. I understand that at any time I may ask questions to Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC if I do not understand any information contained in the NPP.

I, ____________________________________________________________, have had the opportunity to review the Notice of Privacy Practice for Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC and I was offered and;

__________ I ***received*** a copy of the Notice of Privacy Practices (NPP)
INITIAL

__________ I ***declined*** a personal copy of the Notice of Privacy Practices (NPP)
INITIAL

I, ____________________________________________________________, have had the opportunity to review the Patient Bill of Rights, Advance Directive and Physician Ownership and I was offered and;

__________ I ***received*** a copy of the Patient Bill of Rights, Advance Directive and Physician Ownership
INITIAL

__________ I ***declined*** a personal copy of the Patient Bill of Rights, Advance Directive and Physician Ownership
INITIAL

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is posted in our office and copies are available at any time.

## Communication of Protected Health Information

***For Biopsy and / or Medical Results:***

***My preferred method of contact is (please choose all that apply):***

☐ *Email to this address (non-encrypted):*_____________________________________________

☐ *Voice mail message at this phone number:* __________________________________________

☐ *Written letter to my mailing address on file:* ________________________________________

***For Financial Information:***

*You may contact me at this phone number:* _____________________________________________

You may leave a message at the phone number listed above: [ ] Yes [ ] No

## Authorization Form for Use & Disclosure of Protected Health Information

It has been explained to me that disclosures of Personal Health Information (PHI) may be made to family and friends in accordance with my instructions below. It has also been explained that only information relevant to current treatment will be disclosed.
Accordingly, I authorize the disclosure of health care information to (list all that apply):

| Name | Relationship | In Person | By Phone | OK to leave Message | Phone Number |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

*I acknowledge that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC will scan this document and destroy the original, and agree that scanned document is the same as the original.*

____________________________________________ ____________________________
Signature of Patient or Responsible Party Date

____________________________________________ ____________________________
Printed Name of Signature Relationship to Patient

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# Medical History Form

Patient Name: ______________________________________________________ Date: _________________________

Sex: [ ] Male [ ] Female Date of Birth: ____________________ Accompanied by: _____________________________

Consult requested by: [ ] Dr. _________________________ Referred by: [ ] Self [ ] Friend _____________________

Reason for today's visit: [ ] Mohs [ ] Skin Cancer Monitoring [ ] Suspicious Lesion [ ] Other _____________________

**History of today's problem(s) only:** **[ ] No problem today** **[ ] Problems today are listed below**

| | **Problem # 1** | **Problem # 2** | **Problem # 3** |
|---|---|---|---|
| Skin areas involved: | | | |
| How long present? | | | |
| Previously biopsied? | | | |
| Treatment? *(When/Type)*: | | | |

**Check all that apply to today's problem(s):** **[ ]** Not Applicable

**Associated Symptoms**

[ ] Bleeding [ ] Tingling [ ] Itching [ ] Scaly [ ] Pain/sore/tender [ ] Burning
[ ] Spreading [ ] Redness [ ]Other [ ] None

**Height**________________ **Weight**________________

**Past Medical History** *(Check all that apply and add any other important problems)*

[ ] None [ ] High Blood Pressure [ ] Diabetes [ ] Pregnant [ ] Breastfeeding
[ ] Heart Disease [ ] HIV/AIDS [ ] Depression [ ] Anxiety Attacks [ ] Heart Valve Dysfunction
[ ] Hepatitis B [ ] Stroke [ ] Faints Easily [ ] RA/Lupus [ ] Tuberculosis
[ ] Hepatitis C [ ] Renal Failure [ ] Pacemaker [ ] Hepatitis/Cirrhosis [ ] Leukemia/Lymphoma
[ ] Platelet dysfunction [ ] Artificial Joint [ ] Blood Transfusions [ ] Organ Transplant [ ] Myelodysplastic Synd.
[ ] Cancer [ ] Radiation Therapy [ ] Dementia [ ] High Cholesterol [ ] History of MRSA/Staph
[ ] Abnormal Scarring/Keloids [ ] Needs Antibiotics prior to Dental Procedure [ ] Implantable Neurological Device

Do you have a **pacemaker?** [ ] Yes [ ] No Do you have a **defibrillator?** [ ] Yes [ ] No

Previous Skin Cancer: [ ] No [ ] Yes, please list location, date and treatments: ______________________________

______________________________________________________________________________

Other Major Illnesses, Surgeries, Hospitalizations [ ] No [ ] Yes, please list: ______________________________

______________________________________________________________________________

Family history of skin cancer? [ ] None [ ] Basal Cell [ ] Squamous Cell [ ] Melanoma

What is your occupation? ____________________________ Is English your main language? [ ] Yes [ ] No ___________________

Do you have any problems with mobility? [ ] No [ ] Yes ____________________________________________________________

Do you have religious, cultural, spiritual practices that might affect how we treat you? [ ] No [ ] Yes ________________________

Do you have any problems with your vision or hearing that might affect how we treat you? [ ] No [ ] Yes ___________________

Smoking/Tobacco Status (this includes all forms of tobacco products)

- ☐ Current- Year started___________
- ☐ Former- Year started____________ Year stopped___________
- ☐ Type of tobacco product_______________
- ☐ Never

Alcohol Status

How many times in the last year have you had 5 or more drinks in one sitting? ____________

Flu Vaccine

- ☐ Previously immunized- date (include month and year)______________
- ☐ Not immunized

Pneumonia Vaccine

- ☐ Previously immunized- date (include month and year) _______________
- ☐ Not immunized

## Patient Medication Information

Date: _________ Name: ____________________________________________________________ Date of Birth: _____________

****Required Pharmacy Information:**

Pharmacy Name: _________________________________________________ Pharmacy Phone: _________________________

Are you **allergic** to any medications?

[ ] No, I have no known allergies to medication [ ] Yes, I have an allergy to the medication(s) listed below:

Medication: ____________________________________ Medication: _____________________________________

Medication: ____________________________________ Medication: _____________________________________

| **Please list all medications that you are currently taking:**<br>**Prescribed and Over the counter medications**<br>Please include dosage and how often you take them | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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# Financial Policy

**IDENTIFICATION REQUIREMENTS**
This Practice is committed to safeguarding your identity. Federal regulations require verification of your identity at each visit to verify the identity of anyone presenting medical insurance identification. To satisfy the federal requirements, your driver's license will be scanned into your electronic file. This allows us to verify your identity for future visits. Refusal to provide the required identification may delay or prevent your being seen by our physician.

**ASSIGNMENT OF BENEFITS**
I request that payment of authorized Medicare or applicable private insurance benefits be paid directly to Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC, for services provided under their care.

**HEALTH INSURANCE ELIGIBILITY, POLICY UPDATES & NEW INSURANCE**
It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit. In your agreement with your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. It is your responsibility to understand your benefit plan. All prior balances must be paid prior to your visit. We DO NOT participate with all insurances. If we do not accept your insurance, and you wish to be seen at our office, you may elect to pay for services in accordance with the FINANCIAL RESPONSIBILITY listed below. It is important to note that any money paid on your self-pay account will not be applied to your insurance deductible. Failure to provide accurate insurance information, which causes denial of your services, may lead to dismissal from the Practice.

**REFERRALS & AUTHORIZATIONS**
I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of my scheduled appointment, I will be required to reschedule. It is also my responsibility to ascertain if a pre-authorization is required by my insurance company. The billing department will obtain the pre-authorization for me once notified. PLEASE NOTE: When calling your insurance company to find out if a pre-authorization is required for the MOHS procedure, you will want to tell them you are having the procedure done at Christine Rausch, MD, PC, NOT Skin Surgery Center of Virginia, LLC.

**BILLING INFORMATION**
When a surgery or procedure is performed in the Ambulatory Surgery Center (Skin Surgery Center of Virginia, LLC), you may receive TWO (2) SEPARATE BILLS; one (1) from the physician (Christine S. Rausch MD, PC) and one (1) from the Ambulatory Surgery Center. The physician's bill will include all services rendered in the office AND for the physician's treatment in the Ambulatory Surgery Center. The Ambulatory Surgery Center bill is the fee for the use of the Medicare-certified and Joint Commission accredited facility.

**PATHOLOGY & LAB SERVICES**
Some services, such as blood work and tissue obtained from biopsies or surgical specimens, require an outside laboratory for processing and evaluation. Billing for these services will be directly handled by these outside laboratories. While we do attempt to route specimens to the proper lab based on your insurance, we cannot guarantee their participation. By signing, you are giving us permission to provide your insurance information to the lab on your behalf. It is your responsibility to provide accurate and correct insurance information.

**ABN *(Advanced Beneficiary Notice)***
The Federal Medicare program, administered through the Center for Medicare and Medicaid Services (CMS), does not cover many services they consider medically unnecessary or inappropriate. You're responsible for all fees related to these services. You'll be notified, and your signature will be required prior to receiving any potentially uncovered services. Supplemental or secondary insurance to Medicare will not cover services denied by Medicare. Please check with your insurance carrier prior to treatment if you're concerned about these issues.

**MISSED & CANCELLED APPOINTMENTS**
We require at least 48 business hours' notice if you must cancel an appointment. Failure to do so will result in the following cancellation fees: **$100.00 for surgical appointments and $50.00 for office visits.** The office is open Monday through Friday. Missed appointments will require a $50 deposit prior to rescheduling.

**LATE FOR APPOINTMENT**
**If you arrive 15 minutes late or more to your appointment, you will likely be asked to reschedule unless the physician's schedule can accommodate you.**

**This does not mean you will be seen immediately, but we will try to work you in between the other scheduled patients.**

**COSMETIC PROCEDURE**
Patients are expected to pay in full at the time of service. All cosmetic procedure fee(s) will be collected in full at the time of service.

**COLLECTION OF CO-PAYS & DEDUCTIBLES**
Per your agreement with your insurance carrier, you are required to pay all applicable co-payments at the time of service. In addition, if you are insured with a high-deductible insurance plan and have not met your deductible, we may collect the contracted rate for services rendered at the time of service.

**RETURNED CHECKS**
Checks are processed by a third-party vendor. The vendor will directly bill you $35.00 for any check that is returned for insufficient funds.

**FINANCIAL RESPONSIBILITY**
I understand that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC, as a courtesy, will file my insurance claims with insurance companies that the Practice participates with; however, I am ultimately responsible for the full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party understands that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for service rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection fees, including the total unpaid balance due, plus court costs and filing fees incurred by Christine S. Rausch, MD, PC / Skin Surgery Center of Virginia, LLC.

I understand and agree that should Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC, be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1 ½%) per month, eighteen (18%) per annum, beginning on the date of judgment.

All patient balances are billed immediately upon receipt of your insurance plan's Explanation of Benefits. Your remittance is due within ten business days of receipt of your bill. Payment plans are accepted for a six (6) month period, beginning on the first date of service with a balance. If previous arrangements have not been made with our billing department, any account balance outstanding longer than 90 days will be forwarded to a collection agency. Any patient account balance over 90 days past due that does not have a financial payment contract or a credit card on file will be turned over to an outside collection agency. This also includes any patient account balances that have defaulted from their financial payment contract.

**CONSENT FOR THE RELEASE OF MEDICAL RECORDS OR CANCER CLAIM FORMS**
I authorize Christine S. Rausch, MD, PC / Skin Surgery Center of Virginia, LLC, to release necessary medical information to my insurance company, its agents, or any third-party payer in order for payable benefits for these services to be determined. Medical record requests are free for pages 1 – 50. If your request is greater than 50 pages, there will be a fee of $0.25 per page up to a maximum of $15.00. Third-party requests (i.e., attorney, life insurance, disability, etc.) will incur a retrieval fee, $0.25 per page fee, and postage fee. A separate CONSENT FOR THE RELEASE OF MEDICAL RECORDS Form must be completed before your request can be processed.

If you would like the office to complete Cancer Claim Forms, there will be a flat administrative fee of $10.00 per Cancer Claim Form.

All Records/Forms must be picked up or emailed; we do not mail them.

**CREDIT CARD PAYMENTS**

The Practice requires you to have a credit/debit card on file, along with a valid email address, at the time of check-in. We have partnered with Elavon, an electronic payment processor that encrypts and stores your information, providing the highest level of payment security and giving you the peace of mind that your payment for health care services will be handled securely, accurately, and on time. It protects your credit score by avoiding billing mistakes that can easily happen when billing and payments are handled using a manual process.

After your health insurance company processes your claim, you will receive an Explanation of Benefits, which is also sent to us. Your payment responsibility will be charged to your credit/debit card. If you feel an error has been made, call us, and we can stop processing the charge while we investigate. **Refusal to put a card on file requires a $1500 deposit for Mohs Surgery—a $500 deposit for procedures, and a $100 deposit for office visits (inclusive of co-pay).**

On the day of surgery, a $500 deposit will be collected from those patients with Medicare as their primary insurance, and no secondary insurance is available. Patients with no health insurance will be considered "self-pay,"; requiring a **$1500 deposit for Mohs Surgery, a $500 deposit for procedures, and a $150 deposit for office visits. We accept Visa, MasterCard, and Discover.**

**OVERPAYMENTS/REFUNDS**

Once ALL insurance payments have been received and it is deemed you have made an overpayment, we will refund the overpayment to you promptly. All credit balances less than $5.00 (five dollars) can be donated to Access Now, a program administered by the Richmond Academy of Medicine that provides FREE medical care to qualified individuals in the Richmond area. Please indicate if you would like to donate your refund.

☐ Yes, please DONATE my refund of $5.00 or less to ACCESS NOW.

☐ No, I do not wish to donate my refund of $5.00 and would like the funds returned to me.

I acknowledge that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC, will scan this document and destroy the original, and I agree that the scanned document is the same as the original.

________________________________________ ________________________

Signature of Patient or Responsible Party Date

________________________________________ ________________________

Printed Name of Signature Relationship to Patient